

SCHEDULE “C”

GUIDELINES FOR APPLICATION AND INFORMATION REQUIREMENTS FOR LICENSURE OF ADDITIONAL PRIVATE NURSING HOME BEDS WITHIN EXISTING NURSING HOME FACILITIES

This document sets out the requirements that must be followed to obtain a license for new nursing home beds within existing nursing home facilities. Pursuant to requirements under the *Community Care Facilities and Nursing Home Act* and the *Nursing Home Regulations* the application to license a nursing home, with applicable fee, is to be submitted to the Community Care Facilities and Nursing Homes Board (herein referred to as the "Board").

Completed applications, together with all other information and the application fee, are to be submitted to the Community Care Facilities and Nursing Homes Board for review.

Ongoing site visits will be required throughout the application process.

DEFINITIONS:

Applicant: The person applying for a license to operate a nursing home

Operator: The person or organization responsible for the management and operation of a nursing home

To be eligible for licensure for additional beds, the application package must include the completed application form and the following:

1. Proof of Insurance coverage as set out in the *Operational Care Service Standards for Private Nursing Homes*, Standard 2.5
2. Completed Declaration form signed by the applicant.
3. Floor plans that clearly indicate all current and additional nursing bed locations. Floor plans must provide the exact measurements of all additional nursing rooms and dining spaces.
4. Architect and/or engineer stamped plans, if completing a significant expansion or structural renovation to accommodate the additional beds.
5. Updated evacuation plan to include additional beds, if applicable.
6. Staffing proposal.
7. A business plan completed on a form approved by the Board may be required if the Board deems necessary.

Inspection information:

Inspection authorities (e.g. fire, electrical etc.) will be informed by the operator and Department of Health and Wellness that additional nursing home beds have been requested. Each inspection service will determine if a physical inspection of the area is deemed necessary.

- Physical inspection of resident’s room(s), which would include, but not limited to:
 - call bells
 - regulatory requirements for space and equipment

- additional equipment, as required
- access to space e.g. bedrooms, bathrooms (water temperature, wheelchair accessibility)
- additional spaces as required (dietary, bathrooms, tub rooms etc.)
- Staffing:
 - review of proposed schedule
 - review of personnel files demonstrating vetting of all new staff members prior to employment as per Operational and Care Service Standards for Private Nursing Homes Section 7.2

Applications for new dementia beds must include the aforementioned items, with the addition of the following:

- Further information explaining how the operator will operationalize the following areas:
 - Specific education required for dementia units
 - Consistency in staffing
 - Care planning
 - Dementia programming (activities etc.)
 - Safety and physical environments

Please note that applications will be returned before consideration if they are:

- Incomplete, or
- Any required supporting documents are missing

Application Checklist:

As described above, the following documents **MUST BE INCLUDED** in your application for additional nursing beds:

- Application fee, cheque made payable to Minister of Finance
- Completed, signed and dated application form
- Valid insurance certificate
- Signed declaration form
- Floor plans with exact measurements of all potential rooms and dining spaces
- Updated evacuation plan to include any additional nursing beds
- If completing structural renovations, architect and/or engineer stamped plans
- Staffing proposal

Include the additional documents if you're applying for dementia beds:

- Dementia education provided to staff
- Staffing proposal
- Example of a dementia care plan
- Dementia programming available to the residents
- Physical safety considerations the home will provide related to the dementia area

INSURANCE REQUIREMENTS

The Facility, without limiting its obligations or liabilities, provides and maintains policies of insurance satisfactory to the Department of Health and Wellness and in accordance with the minimum requirements as determined by the Risk Management and Insurance Section, Department of Provincial Treasury.

Principle:

The Facility has current and adequate insurance coverage relative to the services provided and the property owned and/or operated.

Criteria:

1. The facility maintains, as a minimum, commercial general liability insurance providing not less than Five Million Dollars (\$5,000,000) coverage and adds the Government as an additional insured and provided whatever information the Government may have required on the insurance that was available. The policy includes, but is not limited to, bodily and personal injury, property damage, non-owned automobile liability, cross liability, blanket contractual liability and 30 days' notice of cancellation to the insured and the Government. Commercial General Liability insurance is endorsed to provide the Government with thirty (30) days advance written notice of cancellation or material damage.
2. The facility purchased and maintained Medical Malpractice Insurance with limits of at least Five Hundred Thousand Dollars (\$500,000).
3. If the facility owns any automobiles licensed to travel on a highway, the Home purchased and maintained Automobile Liability Insurance with combined Bodily Injury / Property Damage limits of at least Two Million Dollars (\$2,000,000).
4. The facility carries a Comprehensive Dishonesty, Disappearance and Destruction policy in an amount not less than Five Thousand Dollars (\$5,000) to cover the property of residents in the event of dishonest acts committed by the Home or the Home's employees.
5. The policies are in a form, and with insurers, satisfactory to the Government. The foregoing insurances are primary and do not require the sharing of any loss by any insurer of the Government, nor any loss by the province's Self-insurance and Risk Management Fund. A "certificate of insurance" was delivered to the Government prior to the execution of the current Service Agreement.

FORM 1

**DEPARTMENT OF HEALTH AND
WELLNESS COMMUNITY CARE
FACILITIES
AND NURSING HOMES BOARD**

**P.O. Box 2000
CHARLOTTETOWN
PRINCE EDWARD ISLAND
C1A 7N8**

PRINCE EDWARD ISLAND

APPLICATION FOR NURSING HOME LICENSE

1. Applicant's Name _____ Phone No. _____
 2. Applicant's Address _____ Postal Code _____
 3. Operator's Name (if different than applicant) _____
 4. Operator's Address _____
Postal Code _____ Phone No. _____
 5. Facility Name _____ Phone No. _____
 6. Facility Address _____ Postal Code _____
 7. Is Property Owned By Applicant? _____ Yes _____ No
Is Property Leased By Applicant? _____ Yes _____ No
- Duration of Lease _____

8. Residents to be admitted

- | | |
|--|--|
| <input type="checkbox"/> Level 1 _____ | <input type="checkbox"/> Level 3 _____ |
| <input type="checkbox"/> Level 2 _____ | <input type="checkbox"/> Level 4 _____ |
| <input type="checkbox"/> Level 5 _____ | |

Give details _____

9. List the services which are available to residents

10. List the number of each type of proposed staff and their qualifications

APPLICATION FOR NURSING HOME LICENSE

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- 11. Attach a proposed work schedule of staff
- 12. Attach a physical description of premises, including type of construction, general condition, site, number and size of rooms, number of storeys, and a sketch of the floor plan
- 13. The following inspections have been completed:

| | YES | NO | DATE COMPLETED |
|------------------------------------|--------------------------|--------------------------|----------------|
| Building Construction Standards | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Electrical Standards | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Elevator Standards (if applicable) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Fire Safety Standards | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hygiene Standards | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

This is to certify that the information contained herein and in the attachments as required is true and correct to the best of my knowledge and belief.

Signature of Applicant

Date Signed

DECLARATION (OPERATOR/ MANAGER)

*To be completed at the request of the CCFNH Board, pursuant to section 6 and 6.1 of the
Community Care Facilities and Nursing Homes Board Act Regulations*

Full Legal Name: _____ Address: _____
Other Name(s) / Aliases: _____
_____ Phone Number: (H) _____
Date of Birth: _____ (C) _____
SIN: _____ Email Address: _____

I, _____, of _____ (city), Province of _____, **SOLEMNLY DECLARE** (check correct response, provide information where required):

1) I have never been convicted of a criminal offence _____

I have previously been convicted of a criminal offence (provide details below) _____

2) I have never been licensed to operate, or been employed in, a community care facility, nursing home, or similar care facility in another province or country. _____

I have been licensed to operate, or have been employed in, a community care facility, Nursing home, or similar care facility in another jurisdiction AND I have had the following (*list if any*) conditions applied to my license or employment. _____

(List Jurisdiction(s), and any applicable license conditions in each jurisdiction):

Declared on the _____ day of _____, 20__.

Declarant